THIS IS A SUMMARY PLAN DESCRIPTION FOR THE HITACHI VANTARA LLC SHORT TERM DISABILITY PLAN. THE PROVISIONS OF THIS SUMMARY APPLY TO DISABILITIES AND PAID FAMILY LEAVES BEGINNING ON OR AFTER JANUARY 1, 2026.

HITACHI
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INTRODUCTION

The purpose of the Hitachi Vantara LLC Short Term Disability (STD) Benefit Plan ("Plan") is to assist you in meeting your reasonable income needs in the event you suffer a short-term disability and are unable to work, you need to care for a sick or injured Family Member, you wish to Bond with a new minor Child, or need to participate in a Qualifying Exigency for the same Family Member.

What follows is a Summary Plan Description (SPD) that is required by the Employee Retirement Income Security Act (ERISA). (Read your ERISA rights on page 5 of this Summary.) Because this summary has been written to conform to Department of Labor (DOL) regulations, it does not contain a complete explanation of each and every provision and term contained in the more comprehensive Plan Document. If your particular circumstances are not described within this summary or if you do not understand something described in this summary, a copy of the entire Plan Document is available for your review upon request at benefits.hitachivantara.com.

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Hitachi Vantara LLC (the Company) has contracted with The Larkin Company (the Claims Administrator) to administer claims in accordance with the Plan Document. The Claims Administrator has been given the ultimate and final authority to determine whether or not you are entitled to Plan benefits.

The Company intends to continue the Plan indefinitely but reserves the right to change or terminate the Plan at any time. If the Plan is terminated and you meet or continue to meet the requirements of the Plan, benefits will continue to be paid for any disability or PFL claim that began before the termination date.

Certain capitalized terms used in this summary have the meanings set forth on pages 6-7.

PARTICIPATION

Who may participate? All Hitachi Vantara LLC employees who are (i) on the U.S. payroll, (ii) working at a Company location within the United States of America or its territories, or (iii) on the U.S. payroll working in the state of California for Hitachi Vantara Federal Corporation, Hitachi Digital LLC, or Hitachi Digital Services LLC are eligible to participate. Interns and individuals performing services for the Company as independent contractors or through an employment or leasing agency are not eligible to participate.

When does my participation in the Plan begin? You are automatically covered as of the date you become eligible, provided, however, you must be at work on the day that your participation in the Plan begins. If you are not at work on that day, your participation will be delayed until you are back at work.

You may reject coverage as a new employee or withdraw from the Plan during a period designated and announced by the Plan administrator as an open enrollment period. If you have rejected coverage or have withdrawn from the Plan, you may enroll during a period designated and announced by the Plan Administrator as an open enrollment period.

When does my participation in the Plan end? As of midnight (at the beginning of the day) when any of the following occurs:

- you cease to be an eligible employee;
- you are no longer employed by the Company;
- you are laid off (provided, however, a temporary shut-down initiated by the Company is not a layoff for the purposes of this Plan);
- on the date you begin an unpaid leave of absence (unless you are on approved leave under the Family and Medical Leave Act (FMLA) or similar state or local law); or
- the Plan terminates.

What is it going to cost me? Effective January 1, 2026, the cost is 0.8% of the first $153,164 of your Earnings with the Company. Any cost to you for state-mandated disability or PFL coverage (or a Company plan established in lieu thereof) will be applied towards the cost of this Plan.

DISABILITY

What is a disability? For the purposes of the Plan, any day or portion of the day:

- you suffer an injury or illness (physical and/or mental) that prevents you from performing the material duties of your regular and customary occupation (or any reasonably related occupation);
- your pregnancy prevents you from performing the material duties of your regular and customary occupation (or any reasonably related occupation);
- you contract or are exposed to a communicable disease (e.g., TB, chickenpox), and your Physician or Practitioner (or a bona fide health official) states, in writing, that you must stay away from work;
- you are under treatment for alcohol or drug abuse. To qualify for benefits you must participate in an accredited residential program or an approved outpatient program that requires your attendance for a minimum of 5 days per week for a minimum of 8 hours per day. Benefits for alcohol or drug abuse treatment are limited to a maximum of 90 days, or
- you have a Terminal Illness as certified by a Physician or Practitioner.

You will not be considered disabled if you are doing work of any kind for the Company or any other employer (including self-employment) for pay or profit without first obtaining approval from the Plan Administrator. You will not be considered disabled if you turn down alternative employment offered by the Company that is within your capabilities and is comparable in status and pay to your regular job.

Who determines when I am disabled? The Claims Administrator, based on a certificate from your Physician or Practitioner based on Objective Medical Evidence and any other information that the Claims Administrator considers to be relevant. If you are disabled as a result of a Terminal Illness, Objective Medical Evidence is not required.

What must I provide to have a valid disability claim? You must submit a claim that includes a certificate from your Physician or Practitioner. The certificate must include the medical facts of your disability, including his or her opinion as to the probable duration of your disability. The certificate must include a diagnosis or diagnostic code prescribed in the International Classification of Diseases. If no diagnosis has been made, a statement of symptoms must be included. All of the above must be based on a physical examination and documented medical history. In order to qualify for benefits, the Claims Administrator may require that you submit other information relevant to your claim. **If you have any questions as to whether or not the supporting documentation you are submitting is acceptable, please call The Larkin Company (Hitachi's authorized claims and leave administrator). You can reach The Larkin Company toll-free at (866) 923-3336 or by emailing Hitachileaves@thelarkincompany.com.**

PAID FAMILY LEAVE (PFL)

When am I eligible for PFL? When you are unable to work because you must provide care to a sick or injured Family Member, wish to Bond with a new, minor Child, or need to participate in a Qualifying Exigency (time off to assist when a Family Member is deployed abroad on active military service). A leave for the purpose of Bonding with a new, minor Child is limited to the first year after the birth, adoption, or foster care placement of that child.

What documentation do I need to care for a sick or injured Family Member? You must provide a certificate from a Physician or Practitioner that supports the Care Recipient's Serious Health Condition. The certificate must include a diagnosis or diagnostic code prescribed in the International Classification of Diseases. If no diagnosis has been made, a statement of symptoms must be included. All of the above must be based on a physical examination and a documented medical history. It must also include the issuer's opinion as to the probable duration of the Care Recipient's Serious Health Condition. Additionally, the Physician or Practitioner must provide an estimated amount of time (days and hours per day) that you are needed to provide care and a statement that the Serious Health Condition warrants your participation to provide care.

What must I provide to have a valid claim for bonding? For the purpose of Bonding with a new, minor Child you must submit a claim and supporting documentation that provides sufficient evidence of (i) your relationship with the child, and (ii) the birth, adoption or foster care placement of the child. The supporting documentation must contain but is not limited to the child's full name, date of birth, gender and, if applicable, date of foster care placement or adoption.

What must I provide to have a valid claim for Qualifying Exigency? For the purpose of leave because of a Qualifying Exigency you must submit a claim and supporting documentation including but not limited to: a statement or description of appropriate facts regarding the Qualifying Exigency; start and end dates of the requested leave period (including frequency and duration for intermittent leave); if meeting with a third party, contact information for the individual or entity; and, a copy of the rest and recuperation orders, if applicable.

BENEFITS

When will my disability benefits begin? On the earliest of the following: (i) your 8th consecutive day of disability (provided you have been treated by a Physician or Practitioner during that 8-day period); (ii) your first day in a hospital; or (iii) your first day of treatment in a Surgical

Clinic or Surgical Unit of a hospital provided you are disabled for at least 8 days as a result of the condition requiring treatment.

Successive periods of disability due to the same or related cause or condition are considered one disability unless separated by a return to your normal work schedule for more than 60 days.

When will my PFL benefits begin? Your PFL benefit will begin on the 1st day that you are on a leave to care for a Family Member with a Serious Health Condition or to bond with a new, minor Child.

A PFL is deemed continuous if taken within the same Twelve-month period.

How much will I receive? If you are disabled or entitled to PFL benefits, you will be paid 80% of your weekly Earnings to a maximum of $4,077 per week.

Partial weeks are paid at a daily rate that is 1/7th of your weekly benefit.

Are limits placed on my benefits? Yes. Your benefits will be limited to 60% of your weekly earnings to a maximum weekly benefit of $1,620 if you have been employed for fewer than 90 days at the time your disability or PFL claim begins.

Will I still be eligible for benefits if I work while claiming benefits? If you return to work on a part-time basis while eligible for disability benefits, your weekly benefit will be reduced by 80% of the income you earn from part-time employment.

If you work intermittently or on a reduced schedule while eligible for PFL benefits, you will receive 80% of your "wage loss" (the difference between your Earnings (defined below) and the amount you are receiving while working intermittently or on a reduced schedule) but never more than $4,077 per week.

While eligible for benefits you must obtain the approval from the Plan Administrator before engaging in employment.

How are benefits determined? Benefits are based on your Earnings. "Earnings" means (i) base pay or (ii) with respect to select sales employees, the Benefit Target Compensation in effect immediately prior to the date your disability or PFL begins. It does not include earnings received from commissions, bonuses, overtime, and other compensation.

If your disability begins while you are on an approved unpaid leave of absence, "Earnings" means (i) base pay, or (ii) with respect to select sales employees, the Benefit Target Compensation in effect in effect just prior to the start date of your leave. It does not include earnings received from commissions, bonuses, overtime, and other compensation.

An increase in your Earnings during a period of disability or PFL will not increase your benefit amount.

What is deducted from my benefit? Any of the following for which you are eligible: (i) temporary or permanent disability payments (whether total or partial), vocational rehabilitation payments, and any other amounts awarded to or allocated to you under workers' compensation or similar occupational disease law; (ii) Company-paid sick leave pay or salary continuation pay during your period of disability, unless the combination of sick leave pay or salary continuation and your benefits does not exceed your regular weekly Earnings; (iii) benefits under a state disability or PFML plan or a Company plan providing disability or PFML benefits in place of a state plan; and (iv) Primary and Dependent Disability or Retirement benefits under the Federal Social Security Act, or any other similar plan or act, provided, however, that any cost-of-living increases in such benefits, effective after the initial reduction in the Plan benefit, will not serve to further reduce the Plan benefit. If you are (or might be) entitled to these benefits but do not apply for them, your benefits from this Plan will be reduced by the amount the Claims Administrator believes you would have been entitled to receive. If you have applied but not yet received these other benefits, you will receive full Plan benefits while waiting to receive them (provided you sign an agreement to reimburse this Plan, up to the amount of payments made, immediately upon receipt of such benefits).

What if someone else injures me? If your disability is the result of injury or illness caused by someone else, you will receive Plan benefits only if you agree to reimburse the Plan from the proceeds of any award you receive in relation to that injury or illness. Any portion of the award remaining after you have reimbursed the Plan for prior benefits will reduce future Plan benefits.

Can benefits be suspended? Yes. The Claims Administrator may request that a Physician or Practitioner examine you at the Company's expense. Your benefits will be suspended as of the date of the examination. However, if the examination establishes that you are still disabled, your benefits will resume retroactive to the examination date. If you fail to furnish information about your disability within 30 days following a written request by the Claims Administrator, your benefits will be suspended. Finally, if you leave your Physician's or Practitioner's care, or you reject the treatment plan recommended by your Physician or Practitioner, your benefits will be suspended. Benefits will resume once you comply with these requirements. In no event will you be paid benefits for the period when you were out of compliance with the Plan.

When do disability benefits end? Benefits are not payable beyond your 52nd week of disability. However, if your disability ends before then (or in the event of your death), your benefits will end as of that day.

With respect to a disability that commenced while you were covered under this Plan, benefits will not terminate solely because you cease to be an employee of Hitachi Vantara LLC.

When do PFL benefits end? Benefits are payable for a maximum of 84 calendar days. However, if the Care Recipient dies or ceases to have a Serious Health Condition or your need to provide care ends before then, your benefit will end as of that date. *You cannot be paid a PFL benefit for more than 84 calendar days in any Twelve-month Period.*

With respect to a PFL claim that commenced while you were covered under this Plan, benefits will not terminate solely because you cease to be an employee of Hitachi Vantara LLC.

Overpayments In the event you are paid benefits by the Plan in excess of those to which you are entitled, the Plan has a right to recover the overpayment. The Claims Administrator will make reasonable arrangements for you to repay the Plan. In no event will you be required to repay more than the amount of benefits paid to you.

EXCLUSIONS

Are there conditions under which I will not be eligible for benefits? You will not receive benefits if:

- you were not a Plan participant when your disability began;
- your illness or injury was self-inflicted unless your underlying injury or illness is otherwise covered by the plan and results from a documented medical condition, i.e., depression or mental illness;
- you became disabled because of your commission or your attempted commission of a felony or other illegal occupation;
- you are incarcerated (in jail or any other facility) as a result of a criminal conviction;
- you are injured in a war (as a civilian or soldier), riot, insurrection, or rebellion;
- you are no longer under the Regular and Continuous Care of a Physician or Practitioner, unless the Claims Administrator determines that your disability does not warrant such attention;
- you are receiving unemployment compensation under any federal or state program;
- your disability stems from alcohol or drug addiction, or from aberrant sexual behavior, and you are confined by court order in an institution or some other place;
- another Family Member is ready, willing, able, and available to provide care to the Care Recipient for the same period of time on a day that you are claiming PFL benefits and providing the required care to that Care Recipient;
- you are receiving unemployment compensation under any federal or state program;
- your Disability is caused by or results from gainful self-employment or employment elsewhere,
- you made false, fraudulent, or misleading statements related to your disability or PFL claim, or you submitted false or fraudulent information or documentation regarding your disability or PFL claim; or
- you are receiving pay under the Worker Adjustment and Retraining Notification (WARN) Act or in-lieu-of-notice pay.

CLAIMS

How do I file a claim? Notify Hitachi's leave and claims administrator, The Larkin Company, at 650 938-0933 or toll-free at 866 923-3336, or by emailing Hitachileaves@thelarkincompany.com as soon as reasonably possible following the commencement of your disability or need to take PFL. The Larkin Company will send you an information packet including claim forms. Fill out the forms and return them to The Larkin Company (see Claims Administrator information on page 7). To avoid losing some or all of your benefits, your claim for benefits must be filed not later than 45 calendar days after the date you would have been eligible to receive benefits (unless you can show it was not reasonably possible for you to comply with this requirement); otherwise, you may lose some or all of your benefits. No claim will be accepted if filed more than 6 months after benefits were payable.

Time limit for a claim decision The Claims Administrator must make a determination no later than 45 days after receipt of your claim. If a decision cannot be made in that period, the Claims Administrator may extend that period up to 60 days (in 30-day increments) provided you are notified, in writing, prior to the expiration of the deadline(s), of the cause of the delay, of the standards on which entitlement is based, of any unresolved issues or additional information needed to resolve those issues, and the date that a decision is expected. If additional information is needed, you will have 45 days in which to provide it.

When can I expect payment? After you have submitted all of the required information, your claim will be evaluated. If it is approved, the amount of your benefit will be calculated, and a check will be sent to you by The Larkin Company. Subsequent payments will be made on the 15th and the end of the month. Information on the check stub will include the date of the next payment and/or if any additional information is required.

Disputing a denied claim If your claim is denied, you will receive written notification of the determination. The notification will be written in a culturally and linguistically appropriate manner and will set forth the following: (i) the

specific reason for the denial; (ii) references to the specific Plan provisions on which the denial is based; (iii) a description of any additional material necessary to perfect your claim and an explanation of why such material or information is necessary; (iv) a description of the Plan's claim review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review; (v) if applicable, the rule (or similar criterion) on which the denial was based or, if the denial was not based on a rule (or similar criterion), a statement that these were not used; (vi) if applicable, an explanation of the scientific or clinical judgment used in making the determination and a statement that such an explanation is available, on request, free of charge; and (vii) an explanation as to why the Plan disagreed with the views of your treating Physician or Practitioner, medical or vocational experts, or the Social Security Administration, if applicable.

If you receive notice that your claim has been denied, you have 180 calendar days following receipt of the denial to file a written request for a review. You may submit any documentation you feel will support your claim including any comments that you feel are relevant to your claim. You are entitled to a copy of the Plan Document and other documents relevant to your claim. Send your written request for a claim review to: **Claims Administrator, Short Term Disability Benefit Plan, Hitachi Vantara LLC, 1376 Roseville Pkwy, Suite 140-393, Roseville, CA 95661.**

Claim review time limit and notification requirements
The Claims Administrator will render a written decision within 45 calendar days of receipt of your request. The review of your claim will: (i) give no weight to the initial denial; (ii) be of your entire file including any new material and arguments you submit; (iii) provide you, free of charge, with any new or additional evidence considered as soon as possible and sufficiently in advance of the end of the 45-day period; (iv) be done by an individual or individuals who neither made the initial denial nor is a subordinate of that individual; and (v) be made with the consultation of a health care professional (with the appropriate training and experience) who was not the health care professional consulted on the initial denial nor a subordinate of that health care professional, if the initial denial was made in consultation with a health care professional or was based in whole or in part on a medical judgment. If new or additional evidence is received and relied upon while your claim is being reviewed, you will be provided with that evidence as soon as possible and sufficiently in advance of the date on which the review of the adverse determination is due and you will be afforded the opportunity to respond.

If a decision cannot be reached within 45 days, you will be notified, in writing, prior to the expiration of that deadline. The notice will include the reason for the delay and the date a decision is expected. In no event will the decision process take more than 90 calendar days from the date your request for review was received.

If, on review, your claim is denied you will receive written notification of the determination. The notification will be written in a culturally and linguistically appropriate manner and will set forth the following: (i) the specific reason(s) for the denial; (ii) reference(s) to the specific Plan provision(s) on which the denial is based; (iii) a statement that you are entitled to receive, free of charge upon request, reasonable access to, and copies of, all documents relevant to your claim; (iv) a statement that you have the right to file a civil suit under Section 502(a) of ERISA no later than 6 months after the date of the final determination; (v) the calendar date on which the 6 month deadline will expire (vi) if applicable, the rule (or similar criterion) on which the denial was based, or, if not applicable, a statement that these were not used; (vii) if applicable, an explanation of the scientific or clinical judgment used in making the determination and a statement that such explanation is available on request, free of charge; and (viii) if applicable, the identity of any medical or vocational experts whose advice was obtained during the decision process, and (ix) a discussion of the decision, including an explanation of the basis for disagreeing with or not following the views presented by the Participant's Physician(s), Practitioner(s) or vocational experts, the views of the medical or vocational experts whose advice was obtained on behalf of the plan, and the disability determination presented by him or her to the Plan made by the Social Security Administration.

ERISA INFORMATION

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants will be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office, all documents governing the Plan, including a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. If you wish to examine any of these documents, contact the Hitachi Vantara LLC Human Resources Department in Santa Clara, CA.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual financial report.

Prudent Action by Plan Fiduciaries

- In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

- If your claim for a Plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to this decision without charge, and to appeal any denial, all within certain time schedules.
- Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.
- If you receive this document through electronic means, you have the right to request, free of charge, a paper copy of this document.

Assistance with Your Questions

If you have any questions about the Plan, contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you may contact the nearest office (listed in your telephone directory) of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor. EBSA also has a national toll-free number: 866 444-EBSA. You may also contact EBSA by writing to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210.

DEFINITIONS FOR KEY TERMS

"**Bond or Bonding**" means to develop a psychological and emotional attachment between yourself and the new minor Child. Bonding involves being in one another's presence.

"Care Provider" means either (i) the Family Member who is providing the required care for a Serious Health Condition, (ii) the Family Member who is Bonding with the New Child, or (iii) the employee who is participating in a Qualifying Exigency.

"**Care Recipient**" means either (i) the Family Member who is receiving care for a Serious Health Condition, or (ii) the new minor Child with whom you are Bonding. For the purposes of a Qualifying Exigency, care recipient is limited to the individual's Spouse, Domestic Partner, Child or Parent in the Armed Forces of the United States.

"**Child**" means a biological, adopted or foster child, a stepchild, a legal ward, a son or daughter of a Domestic Partner, or a child for whom you stand "in loco parentis".

"Claims Administrator" means the entity appointed by the Company for the purposes of processing and adjudicating claims and making determinations on review of denied claims under the Plan in accordance with the terms of the Plan and the Department of Labor claims procedure regulations.

"**Domestic Partner**" means your domestic partner if the domestic partnership meets the Hitachi Vantara LLC group health plan requirements for domestic partnership.

"**Family Member**" means Child, Parent, Parent-in-law, Grandparent, Grandchild, Sibling, Spouse, or Domestic Partner as defined in this section. For Qualifying Exigency, "Family Member" means a Spouse, Domestic Partner, Child, or Parent who is a member of the regular Armed Forces of the United States.

"**Grandchild**" means a Child of one of your children.

"**Grandparent**" means a Parent of one of your Parents or Parents-in-law.

"New Child" means a minor child for whom leave is taken for the purposes of bonding within one year of the child's birth or placement with the Participant or the Participant's Spouse or Domestic Partner.

"Objective Medical Evidence" means a measurable abnormality which is evidenced by one or more standard medical diagnostic procedures including laboratory tests, physical examination findings, X-rays, MRIs, EEGs,

ECGs, CAT scans or similar tests that support the presence of a Disability or indicate a functional limitation. Objective Medical Evidence does not include Physician's or Practitioner's opinions based solely on the acceptance of subjective complaints (e.g., headache, fatigue, pain, and nausea), age, transportation, local labor market and other non-medical factors. To be considered an abnormality, the test result must be clearly recognizable as out of the range of normal for a healthy population; the significance of the abnormality must be understood and accepted in the medical community.

"**Parent**" means a biological, foster or adoptive parent, a stepparent, a legal guardian, or other person who stood "in loco parentis" to you when you were a child.

"**Parent-in-law**" means the Parent to your Spouse or Domestic Partner.

"**Physician**" means a physician or surgeon holding an MD or DO degree, Psychologist, optometrist, dentist, podiatrist, or chiropractic practitioner duly licensed or certified by the state or foreign country in which they practice and acting within the scope of his or her practice. "Psychologist" means a licensed psychologist with a doctoral degree in psychology and who either (i) has at least two (2) years of clinical experience in a recognized health setting, or (ii) has met the standards of the National Register of Health Service Providers in Psychology. A "Physician" does not include you or your Family Member.

"**Practitioner**" means a Nurse Practitioner or physician assistant (provided the physician assistant has performed a physical examination and collaborated with a Physician or surgeon) duly licensed or certified by the state or foreign country in which he or she practices and acting within the scope of his or her license or certification. With regard to disability resulting from pregnancy, childbirth, or postpartum conditions, Practitioner will also include a midwife, Nurse Practitioner, or nurse midwife acting within the scope of his or her license. "Nurse Practitioner" means a licensed Nurse Practitioner who has completed a transition to practice in their licensed state of a minimum of three (3) full-time equivalent years of practice or 4,600 hours. A "Practitioner" does not include you or your Family Member.

"Qualifying Exigency" means time off to assist a Family Member deployed to a foreign country on active military service for reasons including, but not limited to, the following: short-notice deployment; attendance in an official ceremony; attendance in a family support program sponsored by the military; arranging or providing childcare; transferring a Child to a new school; making or updating financial or legal arrangements; attending counseling; accompanying the Family Member while he or she is on short-term rest and recuperation leave; or, attending arrival ceremonies.

"Regular and Continuous Care" means that you personally consult with a Physician or Practitioner at a frequency that is medically necessary to effectively manage and treat your disabling condition(s), in accordance with generally accepted medical standards; and receive appropriate treatment from a Physician and/or Practitioner whose specialty or experience is suited to your disabling condition(s), with such care conforming to generally accepted medical standards.

"**Serious Health Condition**" means an illness, injury, impairment, or physical or mental condition that involves inpatient care in a hospital, hospice, or residential health care facility, or continuing supervision by a health care provider, as defined in Section 825.113 of the federal Family and Medical Leave Act.

"Sibling" means a person related to you by blood, adoption, or affinity through a common legal or biological Parent.

"**Spouse**" means a partner to a lawful marriage.

"Surgical Clinic" means a clinic that (i) is not a part of and not operating under the license of a hospital, (ii) is licensed by the state in which it operates, and (iii) provides treatment for patients who remain fewer than 24 hours. A "Surgical Clinic" does not include the office of a private Physician.

"Surgical Unit" means a unit, located in or operating under the license of a hospital, that provides treatment for patients who remain fewer than 24 hours. A "Surgical Unit" does not include emergency room facilities.

"Terminal Illness" means an illness or end-stage disease that cannot be cured or adequately treated and is expected to result in death within 6 months or less.

"**Twelve-month Period**" means the 365 consecutive days that begins with the first day you first establish a valid claim for PFL.

MISCELLANEOUS

The Hitachi Vantara LLC Short Term Disability Benefit Plan does not provide job protection or return to work rights. You may have job protection rights if you are eligible for leave under the federal Family and Medical Leave Act (FMLA) and/or any other applicable state leave law that provides for such protections. These protections (if eligible) will run concurrently with any approved disability benefits.

PLAN INFORMATION

Plan Name

Hitachi Vantara LLC

Short Term Disability Benefit Plan

Type of Plan

Welfare benefit plan providing temporary disability and family leave benefits.

Funding

All Plan contributions are deposited to a trust and are used for the exclusive purpose of paying Plan benefits and operating expenses.

Employer ID Number

84-3098448

Plan Number

504

Plan Year End

December 31

Claims Administrator

The Larkin Company
1420 E Roseville Pkwy, Ste 140-393
Roseville, CA 95661
www.thelarkincompany.com
866 923-3336 (toll-free)
650 938-0933 (local)
650 938-0943 or 916 594-0131 (fax)

Plan Administrator and Agent for Service of Legal Process

Hitachi Vantara LLC
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Santa Clara, CA 95054